

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Item 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11100

## CERTIFICATE OF DEATH

Reg. Dist. No.

11108  
282

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maddox	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith		Middle Florence Baughman	
4. DATE OF DEATH October 12,		Month 10	Day 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Dr. C. R. Richardson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Walter Saunders Maddox, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>10</u> a.m. <u>7</u> 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 12</u> , 1957, to <u>Oct 12</u> , 1957, that I last saw the deceased alive on <u>Oct 12</u> , 1957, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Roy Guyther</u>		M.D.	
PHYSICIAN'S NAME (Type) Roy Guyther M.D.		Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/14/57	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 10-14-57	24b. REGISTRAR'S SIGNATURE Alma D. Hauser

**BUREAU V.**

OCT 15 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11101

## CERTIFICATE OF DEATH

11109  
282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY		Charles		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		New Port		
St Mary's Hospital				d. STREET ADDRESS		08x1.2		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Female		Judith	Ann	Cole	Oct	14	1957	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
Female		Cloud		Sept. 14, 1954		11. BIRTHPLACE (State or foreign country)		Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		21. 69.
—		—		Maryland		—		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
Joseph Francis Farmer		Ruby Rosemary Cole		—		—		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Aspiration pneumonia		INTERVAL BETWEEN ONSET AND DEATH		
570.5		DUE TO		Infective obstruction				
Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last.		(b)						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10 Oct, 1957, to 13 Oct, 1957, that I last saw the deceased alive on 13 Oct, 1957, and that death occurred at 6 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Leon Berube M.D.								ADDRESS (Street, city or town, state) DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)
Burial		10/13/57		St Aloysius		Leonardtown		Md
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
McClure Mattingly, Leonardtown, Md.				DATE 10-21-57		Alfred D. Hauser		
4000192 XW5								

## CERTIFICATE OF DEATH

REG. NO. 114

BUREAU Y. E.  
RECEIVED  
OCT 22 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11110

11102

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Fulton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Tall Timbers, Md.		c. LENGTH OF STAY IN lb 3 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Decatur 49x-3	
3. NAME OF DECEASED (Type or print) First William Middle Lamar Last COOK		d. STREET ADDRESS 3757 Rainbow Drive	
4. DATE OF DEATH October 5, 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> December 4, 1934	9. AGE (In years last birthday) 22 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pheron Clark Cook		14. MOTHER'S MAIDEN NAME Iva May (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 12-7-55/10-5-57 255-46-7653	
17. INFORMANT U.S. Naval Air Station, Patuxent River, Md. Official U. S. Navy Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL INJURIES INTERVAL BETWEEN ONSET AND DEATH 825X DUE TO IMMEDIATE	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year 1:00 a.m. Oct. 5, 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) Tall Timbers, St. Mary's, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) R. BUFFINGTON, LT MC USNR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/57	
22c. NAME OF CEMETERY OR CEMATORIUM Private		22d. LOCATION (City, town, or county) (State) Decatur, DeKalb, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE 10-8-57	
		24b. REGISTRAR'S SIGNATURE Alan D. Hauser	

DEPARTMENT OF HEALTH-ENVIRONMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. M.

OCT 10 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 7 FilmG222 10-29-57 et  
 11103 **CERTIFICATE OF DEATH**

11111  
 282

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Great Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Peter	Middle H.	Last Dean	4. DATE OF DEATH	Month October	Day 20,	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 1883	9. AGE (In years at birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT James Unkle		Address Great Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Sensitivity</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 22</i> , 1957, to <i>Oct 20</i> , 1957, that I last saw the deceased alive on <i>Oct 20</i> , 1957, and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles Greenwell M.D.</i>				ADDRESS (Street, city or town, state) <i>Charles Greenwell 724</i>		DATE SIGNED <i>10-23-57</i>	
PHYSICIAN'S NAME (Type) Charles Greenwell				Leonardtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/57		22c. NAME OF CEMETERY OR CREMATORIUM St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 10-23-57		24b. REGISTRAR'S SIGNATURE <i>Alma J. Hauser</i>	

## CERTIFICATE OF DEATH

BUREAU V. S.

OCT 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with Part 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11104

## CERTIFICATE OF DEATH

11112  
282

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 8 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Loveville <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Edward Dyson		4. DATE OF DEATH October 20, 1957	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 5, 1955	
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 15 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Howard Dyson		14. MOTHER'S MAIDEN NAME Mary Etta Hebb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ***		16. SOCIAL SECURITY NO. *****	
17. INFORMANT William H. Dyson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho - Pneumonia</u> DUE TO 286.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Profound Malnutrition + Ricketts</u> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 491X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 12, 1957</u> , to <u>October 20, 1957</u> , that I last saw the deceased alive on <u>October 20, 1957</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert T. Fuchs</u> M.D.		ADDRESS (Street, city or town, state) <u>Leonardtown, Md.</u> DATE SIGNED <u>10/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/57	
22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE 10-21-57	
ADDRESS Leonardtown, Maryland		24b. REGISTRAR'S SIGNATURE <u>Alan D. Hauser</u>	

BUREAU Y.

1951 22 150

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22. 1957.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11105

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

11113

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bushwood</b> <b>Rural</b>		c. LENGTH OF STAY IN 1b <b>54 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		x2 Rural Bushwood	
3. NAME OF DECEASED (Type or print) <b>Mary Ada Greene</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard E. Cole</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Holt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>#####</b>	
17. INFORMANT <b>Mr Harry Green e Bushwood, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Cerebral Vascular Accident</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Mechanicsville</b> (County) <b>Maryland</b> (State)	
21. I certify that I attended the deceased from <b>Oct 5</b> , 1957 to <b>Oct 7</b> , 1957, that I last saw the deceased alive on <b>Oct 3</b> , 1957, and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <b>Leon Berube</b> M.D.			
DATE SIGNED <b>10/10/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/8/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart</b>		22d. LOCATION (City, town, or county) <b>Bushwood, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>Glenn D. Hansen</b>		24b. REGISTRAR'S SIGNATURE	
DATE <b>10-11-57</b>			

OCT 14 1957  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11106

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

11114

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		Baby Hall		4. DATE OF DEATH		Month Day Year	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10-4-57		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph H. Hall		14. MOTHER'S MAIDEN NAME Margaret C. Latham					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph H. Hall, Mechanicsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Prema furity				INTERVAL BETWEEN ONSET AND DEATH	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 40 ct. 1957 to 40 ct. 1957, that I last saw the deceased alive on 40 ct. 1957, and that death occurred at 8 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Leon Berube M.D.						ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) Leon Berube						DATE SIGNED 10/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-57		22c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius		22d. LOCATION (City, town, or county) Leonardtown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingly, Leonardtown, Md.		ADDRESS 2078235 XVO		24a. REC'D BY REGISTRAR DATE 10-11-57		24b. REGISTRAR'S SIGNATURE Glen A. Hauser	

BUREAU Y. S.

OCT 14 1957

REGELIV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11115

11107

## CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hollywood				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS 1 Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Nannie		First	Middle	Last	4. DATE OF DEATH October 25	Month	Day	Year
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 16, 1860	9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Clifton T. Hall - Hollywood, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		An arteriosclerotic C.V. disease with congestive heart failure. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mechanicsville, Md.		20f. (City or town) Mechanicsville, Md.		(County) (State)
21. I certify that I attended the deceased from <u>Aug 15</u> , 1957, to <u>Oct 25</u> , 1957, that I last saw the deceased alive on <u>Oct 25</u> , 1957, and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Mechanicsville, Md.		
ACTUAL SIGNATURE <i>J. Roy Guyther</i>		M.D.				DATE SIGNED 10/25/57		
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD				Mechanicsville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORIAL Maplewood Cemetery		22d. LOCATION (City, town, or county) Gordonsville, Virginia		(State)
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 10-30-57		24b. REGISTRAR'S SIGNATURE John D. Hauser		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

## CERTIFICATE OF DEATH

BUREAU V. S.

OCT 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11108 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11116

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Lexington Park</b>		c. LENGTH OF STAY IN lb <b>5 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Chester Ambrose Hill</b>		4. DATE OF DEATH Month <b>October</b>	Day Year <b>14, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1900</b>
9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b>	11. IF UNDER 24 HRS. Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C. T. Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bus Operator</b>	11. BIRTHPLACE (State or foreign country) <b>Chaptico, Maryland</b>
13. FATHER'S NAME <b>Robert Hill</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Bowles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-6800</b>	17. INFORMANT Address <b>Gladys B. Hill RFD 1 Box 130 Lexington-Park, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd</i>	DATE SIGNED 10/15/57		
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. James</b>	22d. LOCATION (City, town, or county) (State) <b>St. Mary's City, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>10-15-57</b>
			24b. REGISTRAR'S SIGNATURE <i>Alma J. Hauser</i>

MANAN STATE OF OREGON - BUREAU OF MEDICAL EXAMINERS CERTIFICATE OF DEATH

BUREAU Y. 8

OCT 16 1957

RECEIVED

11117

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 282

<span style="font-size: 2em; font-weight: bold;">M</span> <span style="font-size: 1.5em; font-weight: bold;">11109</span>		<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b> <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>										
		<b>1. PLACE OF DEATH</b> a. COUNTY St. Mary's MARYLAND					<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Knox					
<span style="font-size: 1.5em; font-weight: bold;">00</span>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Tall Timbers, Md.			c. LENGTH OF STAY IN 1b 5 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galesburg 51X-3			d. STREET ADDRESS 598 Monmouth Blvd.		
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<span style="font-size: 1.5em; font-weight: bold;">I</span>		<b>3. NAME OF DECEASED</b> (Type or print) Charles Edward MC GEARY			First Middle Last	<b>4. DATE OF DEATH</b> October 5, 1957		Month Day Year				
		<b>5. SEX</b> Male			<b>6. COLOR OR RACE</b> Caucasian		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> 11-12-37		<b>9. AGE (In years last birthday)</b> 19 yrs.	
<span style="font-size: 1.5em; font-weight: bold;">10</span>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Mariner			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> U.S. Navy			<b>11. BIRTHPLACE</b> (State or foreign country) Minnesota			<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
		<b>13. FATHER'S NAME</b> James McGahey			<b>14. MOTHER'S MAIDEN NAME</b> Eldora Guenther							
<span style="font-size: 1.5em; font-weight: bold;">15</span>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) Yes			<b>16. SOCIAL SECURITY NO.</b> 6/56 to 10/57			<b>17. INFORMANT</b> U.S. Naval Air Station, Patuxent River, Maryland - Official Navy Records.			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 825X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)	
		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 825X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)										
<span style="font-size: 1.5em; font-weight: bold;">19</span>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
		<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident							
<span style="font-size: 1.5em; font-weight: bold;">20</span>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. Oct 5, 1957		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) Highway		<b>20f. (City or town)</b> Tall Timber, St. Mary's, Md.		<b>(County)</b> <b>(State)</b>		
		<b>21.</b> I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>		<b>DATE SIGNED</b> 10-7-57								
<span style="font-size: 1.5em; font-weight: bold;">22</span>		<b>22a. CHIEF MEDICAL EXAMINER</b> W.M. D. BOYD, M.D. Actual Signature		<b>22b. ASSISTANT MEDICAL EXAMINER</b> M. D. BOYD, M.D.		<b>22c. DEPUTY MEDICAL EXAMINER</b> D. M. BOYD, M.D.		<b>22d. LOCATION</b> (City, town, or county) Galesburg, Knox Co. Ill.				
		<b>22d. LOCATION</b> (City, town, or county) Galesburg, Knox Co. Ill.		<b>22d. LOCATION</b> (City, town, or county) Galesburg, Knox Co. Ill.		<b>22d. LOCATION</b> (City, town, or county) Galesburg, Knox Co. Ill.		<b>22d. LOCATION</b> (City, town, or county) Galesburg, Knox Co. Ill.				
<span style="font-size: 1.5em; font-weight: bold;">23</span>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> W.C. Mattingley Leonardtown, Maryland			<b>23. ADDRESS</b> ADDRESS			<b>24a. REC'D BY REGISTRAR</b> DATE 10-8-57		<b>24b. REGISTRAR'S SIGNATURE</b> Alan D. Hauser		
		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> W.C. Mattingley Leonardtown, Maryland			<b>23. ADDRESS</b> ADDRESS			<b>24a. REC'D BY REGISTRAR</b> DATE 10-8-57		<b>24b. REGISTRAR'S SIGNATURE</b> Alan D. Hauser		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

OCT 10 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11118

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park, x2	
3. NAME OF DECEASED (Type or print) First Nora Middle Barrett Last Moffatt		4. DATE OF DEATH Month October, Day 1, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR 2 months 17 days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lawrence Barrett		14. MOTHER'S MAIDEN NAME Mary McCarthy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Arthur L. Rysticken 403 St Lo Place
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under: cause (b), lying cause lost.		Lexington Park, Maryland Heart Failure INTERVAL BETWEEN ONSET AND DEATH 1 day.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO Hyptertensive Cardio Vascular Disease DUE TO Chronic Pyonephritis		5 years 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-29-</u> , 19 <u>50</u> , to <u>Oct 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Wm H. Patrick</u> M.D. ADDRESS (Street, city or town, state) <u>323 Midway Dr.</u> DATE SIGNED <u>10-1-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/57	22c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet
22d. LOCATION (City, town, or county) Braidwood, Will, Illinois			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE 10-1-57	24b. REGISTRAR'S SIGNATURE <u>Alma D. Fausner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BUREAU V. 2

OCT 3 1957

# REGELYÉD

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

## MARYLAND STATE DEPARTMENT-OF HEALTH-BALTIMORE, 18

11119

## 11111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlotte Hall</b>		c. LENGTH OF STAY IN 1b <b>Suitland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2314 Lakewood Street</b>	
3. NAME OF DECEASED (Type or print) <b>Andrew</b>		First <b>Paul</b>	Middle <b>Norris</b>
4. DATE OF DEATH Month <b>October</b>	Day <b>30</b>	Year <b>1957</b>	5. SEX <b>Male</b>
6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1925</b>	9. AGE (In years last birthday) <b>32</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Safeway Stores</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Herbert E. Norris</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>220-16-9108</b>	17. INFORMANT Address <b>Mrs Virginia Norris, 2314 Lakewood St. Suitland, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was operator of car which ran in back of Truck</b>	
20c. TIME OF INJURY Hour <b>5:53</b>	Month, Day, Year <b>Oct. 30, 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 5</b>
20f. (City or town) <b>Charlotte Hall</b>	(County) <b>St. Mary's</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22. ACTUAL SIGNATURE <i>W. D. Boyd</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10/30/57</b>
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Nov. 2, 1957</b>	22c. DATE THEREOF <b>Nov. 2, 1957</b>	22d. NAME OF CEMETERY OR CREMATORIAL <b>Our Lady's</b>	LOCATION (City, town, or county) <b>Medley's Neck, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>	ADDRESS <b>Leonardtown, Maryland</b>	24a. REC'D BY REGISTRAR <b>10/31/57</b>	24b. REGISTRAR'S SIGNATURE <i>Alan D. Hauser</i>

WILSON COUNTY, TENNESSEE - DEPARTMENT OF HIGHWAY - SURVEYING DEPARTMENT

BUREAU U. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG222 11-5-57 et

11112

## CERTIFICATE OF DEATH

11120  
282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS # 20 Adams Pl.	
3. NAME OF DECEASED (Type or print) Mary Ellen Queen		4. DATE OF DEATH October 5 1957	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 6, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Hopewell		14. MOTHER'S MAIDEN NAME Maria Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Jerome R. Hopewell - Lexington Park, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 5 - 7 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. n. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Ernest D. Rehm M.D. <i>80457</i>			
PHYSICIAN'S NAME (Type) Ernest Rehm, MD		Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/9/57	22c. NAME OF CEMETERY OR CREMATORIAL Holy Face Cemetery	22d. LOCATION (City, town, or county) (State) Great Mills, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 10-8-57 24b. REGISTRAR'S SIGNATURE Elan D. Housey	

1413 - CERTIFICATE OF DEATH  
WISCONSIN STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## BUREAU V. S.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11121

282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas		b. COUNTY Grayson		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Tall Timbers, Md.		c. LENGTH OF STAY IN 1b 3 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dennison		d. STREET ADDRESS 205 N. 8th St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clarence		First	Middle	Last	4. DATE OF DEATH October 5, 1957	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-29-37	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel Ray			14. MOTHER'S MAIDEN NAME Emily S. Davis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 2/56 to 10/57			16. SOCIAL SECURITY NO. 465 48 9164		17. INFORMANT U.S. Naval Air Station, Patuxent River, Md. - Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE, SKULL, FRONTAL, MULTIPLE 825X DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) (a), stating the underlying cause last. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident						
20c. TIME OF INJURY Hour a. m. 1:00 PM		Month, Day, Year Oct 5 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Tall Timbers, St. Mary's, Md.	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R. BUFFINGTON, LT MC USNR		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-7-57				
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/57		22c. NAME OF CEMETERY OR CREMATORIAL Denison		22d. LOCATION (City, town, or county) Denison, Garyson, Texas		
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 10-8-57		24b. REGISTRAR'S SIGNATURE Alan D. Hoyer		

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OCT 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11122

Reg. Dist. No. 282

11114

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. LENGTH OF STAY IN TB x2 Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Hollywood	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Francis		First Redmond	Middle Last 4. DATE OF DEATH October 12, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Patuxent Motors	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Millard Redmond		14. MOTHER'S MAIDEN NAME Edna Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 578-48-1648	
No		17. INFORMANT Mrs Norbert Hammett California, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Fracture Skull DUE TO	
DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Car went out of control hit a tree	
20c. TIME OF INJURY 6:40 p.m. 10/12/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mill Pond Road		20f. (City or town) Hollywood, (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William D. Boyd M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10/12/57	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/57	
22c. NAME OF CEMETERY OR CREMATORIAL St. John's		22d. LOCATION (City, town, or county) Hollywood, (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE 10-14-57	
		24b. REGISTRAR'S SIGNATURE Glenn C. Hauser	

MANUFACTURER'S CERTIFICATE OF DATA

BUREAU V. S.  
RECEIVED  
OCT 15 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11123

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH October 9, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 30, 1885	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 8 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman			10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Ned Robrecht			14. MOTHER'S MAIDEN NAME Emma Stevens		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 579-09-5553B		17. INFORMANT Mrs Florence Robrecht	
Address St. George Island, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>High Blood Pressure</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Coronary Artery Disease</i> DUE TO <i>High Blood Pressure</i> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month Doy Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Great Mills, Md.	(County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ernest D. Rehm</i> M.D. ADDRESS (Street, city or town, state) <i>161 Bay St., Great Mills, Md.</i> DATE SIGNED <i>10-11-57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/12/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Francis Xavier</i>	22d. LOCATION (City, town, or county) (State) St. George Island, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.C. Mattingley Leonardtown, Maryland</i>			ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <i>Dean D. Hauser</i>
				DATE <i>10-11-57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.  
OCT 14 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**11116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Dameron</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>State Highway</b>		d. STREET ADDRESS <b>1 Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ronald</b>	Middle <b>Dameron</b>	Last <b>Stewart</b>
4. DATE OF DEATH	Month <b>October</b>	Day <b>4</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1934</b>
9. AGE (In years last birthday) <b>23 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chaufer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Moving Van Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph R. Stewart</b>		14. MOTHER'S MAIDEN NAME <b>Madeline A. Dameron</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Address</b>	
17. INFORMANT <b>J. Allen Dameron - Dameron, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Skull</b> DUE TO <b>Fracture Skull</b> INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>823X</b> DUE TO <b>Fracture Skull</b>			
cause lost. (c) <b>Fracture Skull</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>was driving car on Great Mills Rd &amp; hit a pole</b>	
20c. TIME OF INJURY Hour <b>11:00</b> p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>State Rd</b>
20f. (City or town) <b>Great Mills</b>	(County) <b>St. Marys</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Wm. D. Boyd</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/15/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/8/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Michaels Cemetery</b>	22d. LOCATION (City, town, or county) <b>Ridge, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>D.B. Robinson</b>	ADDRESS <b>Leonardtown, Md.</b>	24a. REC'D BY REGISTRAR <b>DATE 10-8-57</b>	24b. REGISTRAR'S SIGNATURE <b>Plan D. Hauser</b>

MISSOURI STATE DEPARTMENT OF HEALTH-DEATH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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OCT 9 1957

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